emailed validation letter 2/26/10

RECEIVED
FEB 10 2010
OFFICE OF INSPECTOR GENERAL

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 2-10-10
Amount $ 1875 —

Ck# 10777

I. IDENTIFICATION

Name: Williamsburg Nursing Home
Address: Po Box 719
City/County/Zip: Williamsburg, Whitley, 40769
Telephone number: 606 549-4321
Administrator: Michelle JARboe
Date facility operation began at current address: 3-27-78
Date facility began operation under current owner: 3-27-78

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	~~125~~	
Nursing Home		
Nursing Facility	125	
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State
County
City
(Private)

(Profit)
Nonprofit

Individual
Partnership
(Corporation)

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Williamsburg Nursing Home, Inc
Po Box 1450
Corbin Ky 40702

(OVER)

2/28

If facility owned or leased by a corporation, complete the following:

Name of corporation Williamsburg Nursing Home, Inc

Address of corporation P.O. Box 719, Williamsburg, Ky 40769

President or Chairman Terry E. Forcht

Vice President Rodney Shockley

Secretary Jackie Willis

Treasurer

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
First Corbin Long-Term Care PO Box 1450 Corbin Ky 40702	

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Michelle Jarboe — Signature of authorized representative

Administrator — Title

1/28/10 — Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)